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ABSTRACT

An ongoing project is being conducted in San Francisco, California to study the social and psychological factors among the elderly which influence their utilization of outpatient health services. A preliminary study of the project explored associations between the informal support network and the formal social support system as they converged in the delivery of outpatient services. Objective, subjective, and observational data were collected on 100 patients aged 65 years and older who were drawn from four major hospital clinics in the city. Patient medical records were examined and interviews were conducted with outpatients and with clinic staff. An initial assumption that latent social needs would be a significant factor in predicting high rates of clinic use was not supported. In fact, those elderly with better social supports were more likely to go to the clinic for non-serious complaints. Findings suggest that comprehensive socially-oriented outpatient care may forestall hospitalization or reduce the number of hospitalized days. Thus the possibility is suggested that a setting which encourages use ultimately might be more economical. Current research is underway to identify linkages between the informal and formal networks in order to establish those situations in which the formal system in health care settings complements the informal system and those in which it substitutes or compensates for deficiencies in the informal system. (Author/NB)

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NonMedical Factors in Elderly Outpatient Care - The Relationship Between Formal and Informal Support Systems

Barbara M. Barer, and Colleen L. Johnson

ABSTRACT

This preliminary study of 100 patients aged 65 years and older drawn from a 4 major hospital clinics in San Francisco explored associations between the informal support network and the formal social support system as they converged in the delivery of outpatient services. Objective, subjective and observational data were collected through an examination of patient medical records, interviews with outpatients and staff interviews in the clinics.

Findings and Implications:

Our initial assumption that latent social needs would be a significant factor in predicting high rates of clinic use was not supported. In fact, those elderly with better social supports were more likely to go to the clinic for non-serious complaints. Findings suggest that comprehensive socially oriented outpatient care may forestall hospitalization or reduce the number of hospitalized days. Thus the possibility is suggested that a setting which encourages utilization ultimately might be more economical.

Current research is underway to identify linkages between the informal and formal network in order to establish those situations in which the formal system in health care settings complements the informal system and those in which it substitutes or compensates for its deficiencies.

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NONMEDICAL FACTORS IN ELDERLY OUTPATIENT CARE - THE RELATIONSHIP BETWEEN FORMAL AND INFORMAL SUPPORT SYSTEMS

Barbara M. Barer, MSW and Colleen L. Johnson, Phd

This is a preliminary report of an ongoing project being conducted in the city of San Francisco to study the social and psychological factors among the elderly which influence their utilization of outpatient health services.

It is well documented that Americans over the age of 65 consume over one quarter of the national health care expenditures. Obviously some of this is accounted for by the increased medical needs stemming from higher incidence of chronic disease in old age. However, two other possible causes of high use are gaining attention.

1. Those factors inherent in the health care system that might encourage high use, and
2. Those factors related to psychosocial needs of older patients.

It is recognized that patients will come to the doctor or to a clinic to:

1. alleviate stress
2. corbat loneliness, or,
3. gain access to social supports.

In other words, what nonmedical factors are associated with patterns of utilization in the health care system?

We were primarily interested in ascertaining

1.Do patients go to a doctor for nonmedical needs because they don't know where else to go, that is they are not aware of less costly community services, or,

2. Do some elderly turn to the health care system as a substitute for services usually provided by family members.

In particular, do the more isolated elderly, those with abbreviated social networks, make more medical appointments?

From initial pilot research, we collected data that generated hypotheses which are now being tested in a larger study funded by the National Institute in Aging. I will refer to that study a little later. First, let me tell you about the preliminary study and how we did it.

METHODS

The Setting

A total of 83 outpatients was interviewed at 4 research settings in San Francisco, an average of 20 subjects each from the general medical clinics at the Veterans Administration Hospital at Fort Miley, San Francisco General Hospital, Mt. Zion Hospital and St. Mary's Hospital.The four hospital settings share some characteristics. All are postgraduate teaching settings and have residents who rotate through the clinic. All generally draw from a population with a high proportion qualifying for MediCal and SSI, so many patients treated at these clinics cannot afford a private physician.

Sample Characteristics

Our selection criteria specified inclusion of all outpatients 65 years of age or older who could speak English and who were mentally competent. All other socio-demographic characteristics varied.
The mean age of the sample was 74.1 with small differences between clinics. Thus it is a relatively old population who can be predicted to have a high incidence of chronic illness and functional impairment. For the sample as a whole, males and females are evenly distributed.

Data Collection

Three types of data were collected:

1. Subjective data from open-ended interview questions on health status, daily activities, family and social relationships, life situation, satisfaction with clinic services and mood.
2. Observational data of the clinic itself - of the staff and patients interactions.
3. Objective data from patient reports and an examination of medical records.

1.Each subject was interviewed in a secluded area of the clinic waiting room while waiting to see the doctor. Although a list of questions guided the discussions, the respondent was given sufficient opportunity to speak freely about his/her worries and concerns.

2.Observations were made of the patient's interactions in the clinic. We sat off to one side and observed individuals, for example, if they sat passively, read, smoked or ate, walked around, talked with a person next to them, came with someone, chatted with staff, etc.

3.The subjects' medical records were abstracted for data on their utilization patterns during the previous 12 months, including number and length of hospitalizations, emergency room visits, outpatient clinic visits, consultations and referral, use of ancillary services, and number of prescription drugs.

Illustrative of the kind of open-ended interview questions used, are the following:
To get at the social implications of a person's medical appointment we asked respondents

- why they came to the clinic that day,
- how they arranged to get there,
- if anyone came with them,
- who initiated the appointment,
- what they expect to occur during their visit today,
- what they would be doing if they weren't at the clinic today and
- what other activities are planned for the day, e.g. lunch out.

Another series of questions, which are standard and were designed by David Mechanic, were asked to ascertain their propensity to seek medical care e.g. whether they would treat these conditions themselves, or go to the doctor :

e.g. throwing up that lasted a day
heavy cold with a fever of 100
a cough that lasted a week
diarrhea lasting more than a day
vague pains in the legs
feeling weak all over

In terms of their assessment of the health care setting we asked questions such as:

- if they felt comfortable confiding in anyone at the clinic, - how they felt about talking over problems with their doctor,
- and we probed for reasons why people do and do not like to visit their doctor.

Along with some standard measures of social support such as number of phone calls and visits during the week from family and friends, we asked questions such as:

-who you would expect to call regularly if they knew you were not feeling well,
-who you would ask to get some groceries for you if you could not,
-who would take care of you during a 2 week recuperation from the hospital,
-who do you talk to when you feel down in the dumps.

We often used a variety of probes to elicit responses and there was a lot of leeway in how questions were worded in order to gain qualitative data. Questioning was consistently open-ended with no forced choice responses.

CONCLUSIONS

First, our initial assumption that latent social needs would be a significant factor in predicting high rates of clinic use was not supported. That is, we did not find that persons in need of purely social support were more likely to come into the clinic. On the contrary, those with better social supports were more likely to go to the doctor.

This may be explained by the presence of family members who can encourage a patient to seek medical care, or who can provide transportation, or actually set up the appointment for the patient.

Secondly, at Mount Zion and St. Mary's Clinics we found an association which was statistically significant, between high outpatient use and fewer hospitalizations. This suggests that monitoring of chronic conditions can reduce acute episodes requiring emergency room admission or hospitalization, which are much more costly kinds of care than outpatient care.

Utilization varied, not usually because of social integration and not necessarily because of level of impairment, but, what turned out to be a most interesting finding which we had not anticipated, was the influence of the health care setting. Most of these older people came to the clinic each time because they were told to by their doctor, for monitoring chronic conditions.

In the course of conducting the research it became apparent that the organizational setting where individuals receive their health care, plays a significant role in determining utilization. Different clinics treat their patient populations in different ways. Therefore it became apparent that it was important to study not only individual health behaviours and psychosocial supports, but also the organizational structure of each facility. Thus the research led us to discover an additional variable which we had not previously considered, namely, the organizational setting in which the older patient receives medical care.

To review the findings of our preliminary study of "Non medical factors in elderly outpatient care":

1. Patients with better social supports are more likely to go to the doctor.
2. A statistically significant association was found between high outpatient use and fewer hospitalizations.
3. Organizational setting itself influences the elderly's health care utilization.

There is a difference between a crisis/cure approach such as found at San Francisco General, the paternalistic medical model at the VA Clinic with the authority system of the Doctor and the obedient patient, and that of a comprehensively integrated medical/social services clinic.

These findings were incorporated into the proposal for our current study where we are particularly interested in further exploring two things,

1. The setting and how it works as a mediating variable, and
2. The link between formal and informal support systems.

With regard to the setting, our population is being drawn from outpatient clinics at Mount Zion and St. Mary's hospitals which serve a high risk MediCal, SSI population. Both clinics offer social services along with the provision of health care.

And, specifically of interest to us here today is the exploration of the link between the formal and informal support system. That is, how formal supports impact the informal system and how the informal social network which supports older people interacts with the formal system and the utilization of health care.

Our new sample consists of 200 patients, 100 drawn from Mount Zion and 100 from St. Mary's. At this point we have interviewed about one third of the sample. This being a larger scale study, the interview format is more comprehensive, extensive, and in-depth and interviews are being conducted in the respondent's home, rather than in a corner of the outpatient clinic.

From the people we interviewed in the pilot study we know that they are predominantly people with high needs. We have theortetically described four categories of patients according to their use of the health care system in relation to their social network. I will describe these four categories to you and give you a case example of each.

1. An abbreviated social network

This is defined as the absence or unavailability of a spouse, children, friends or a relative identified as close or a confidante, or, those who report no contacts the previous week with a relative or friend. We predict that the health care system will compensate for these deficiencies as evidenced by a high level of utilization of health and social services.

Typical of the patient categorized here is Mr. Franklin,
He is a 73 year old man, widowed and retired for 8 years, has 4th grade education, lives alone in an apartment which consists of one room dominated by a bed, with a kitchen off to the side. There is a notice above his bed, what to do in case of insulin shock. His one 19 year old son lives with an Aunt out of state. He has a brother and cousin in New Orleans who call on occasion. Thanksgiving he spent alone in his apartment. He doesn't know his neighbors, describes himself as being a "loner" and reports "no trouble with health."

His medical records show that he's diabetic, takes insulin, suffers from hypertension, multi infarct dementia, has a small bowel obstruction and right foot ulcer with pain. He goes to the clinic on the average of once a week where his blood pressure in monitored. He

reports "feeling fine", and the medical record notes concern regarding compliance.
He manages on his own with the help of a home care worker who comes in 5 days a week from 8 a.m. to 11 a.m. She prepares his weekend meals ahead of time. Mr. Franklin responds that "the girl does everything". This is a case that we describe as having high health services, high social services that compensate for the lack of informal supports.

2. An active social network
This is defined as living with others and having more than weekly contact with a spouse and/or children and at least two other friends or close relatives, or,
at least four weekly contacts with friends and relatives and the presence of a confidante. We predict that the health care system will complement the family as evidenced by high levels of network contacts, high levels of health services and low levels of social services.

Mrs. Clark is a 79 year old black woman with an 8th grade education. She has 8 children, 5 daughters and 3 sons. Her youngest divorced son lives with her, and another son and his family live upstairs. The house is dilapidated, on a main street in a poor neighborhood, with an old smashed up car in the driveway. Inside, the living room is cluttered, lots of family photos around and a canary singing in a cage. Her grandaughter, herself a grandmother, was visiting, and initially she provided family data, figuring out who had who and calculating on a calculator that Mrs. Clark had 32 grandchildren, 63 great granchildren and 1 great great grandchild.

Mrs. Clark has lots of company all the time, daily contact with her sons, a brother who visits regularly and a best friend with whom she often eats lunch. On Wednesdays she goes to a Mission meeting at her church and has lunch. In the past year Mrs. Clark has been seen at the Clinic twice a month to monitor her hypertension. She has renal isufficiency hypertension, left leg weakness, chronic anemia, and arthritis.

Through social services she is provided with a homemaker twice a week who cleans her house, fixes her hair for her. She has cab vouchers which she uses to go to her Clinic appointments. She says "I don't ask my children to do too much, maybe iron something for me or turn the mattress on the bed." So this case illustrates a situation where the social and health care services complement the provision of support from informal sources.

3. A dysfunctional network
This is defined as those having relatives who could be potentially available but the relationships are reported to be conflictual, of poor quality, or unhelpful. We hypothesize that with low levels of social contact with members of the network, that there will be high levels of utilization of health and social services. Usually with confluctual family relationships contact is discontinued and the patient has no expectations of help from those sources.

We have fewer cases of dysfunctional networks but we do encounter networks which do not operate supportively, either because of family conflict or simply as a result of benign neglect. "The chidlren are busy with their own problems."

Characteristic of a dysfunctional system is the family of Mr. Dean. He is a 66 year old man with some mental health problems and is on psychotropic medications. He has a history of job losses. His wife is alcoholic, in poor health and they are the parents of 5 children. Their home is in very poor condition, described as being rodent infested. Mr. Dean sees a psychiatrist and has a record of frequent clinic visits.

He describes his children as follows "The children don't give much care or comfort to us. Wendy comes off and on though. She swept the floor last time she was over. Donald sometimes cleans up, puts in light bulbs. Tammy used to come every 3 months but my wife got drunk at Tammy's wedding and that cooled things."

The family fits our description of dysfunctional, but services are not being substituted by the formal system at this point.

4. A Noncompensatory network
This is defined as those elderly who have few network resources and little support from the health care system. These are high risk individuals who have a high level of unmet needs. This will be evident by a low incidence of network contacts and low levels of utilization. These are the elderly who inadvertently slip through the bureaucractic cracks.

Such is the case of Mrs. Norman, an 87 year old woman, widowed 6 years, having been married since she was 15 years old. Five years ago her only son died. She doesn't know how many grandchildren she has. One brother and sister live in Texas and Mrs. Norman lives alone in public housing. She had the gas oven on with the door open for heat, insects were on the table, mouse traps on the floor and in fact, mice were scampering around. She was described "as though she has no contact with the world outside her kitchen door. She was a little incoherent, four times asking the interviewer why she was there.

The interview terminated before completion because of her limited ability to respond. Mrs. Norman said she hadn't been feeling well but didn't know how to get the help she needed.

She had sparse visits to the medical clinic, broken appointments and the medical chart noted that she had "appropriate situational depression, with placement into adult living situation being looked into." Also noted was that a social worker with public housing was involved but that was 2 years ago. It appears that without the intervention of formal supports, Mrs. Norman is at high risk for institutionalization.

To sum up, our object is to explore relationships between formal and informal supports as they converge in the delivery of outpatient services to the elderly. We hypothesize that:

1. In the absence of informal supports the clinic compensates for depeleted resources.
2. When the family and informal network are overburdened, the clinic complements their resources, and,
3. When family and other primary relationships are unsatisfactory, the clinic substitutes for those relationships.

Like reports from survey research, the majority of elderly we are seeing have someone in an informal network who can potentially help them, at least intermittently. However, to-day's family systems are such that ongoing demands cannot be endured by them. The family's vulnerability and weakened resources are particularly apparent in inner-city, low income areas.

The question as to whether the formal support system replaces the informal support network is not the central issue. Rather, what are the personal, and financial, resources of individuals in the network, and what can be expected of them over an extended period of time.

Our preliminary indictions are that for the population we are studying, continuance of community living would be seriously threatened without the support of the long term care arranged through their contact with the outpatient clinic.

The question raised for service providers is:
Is it the role of the health care system to function as a source of social support to those with limited social and economic resources in our society, or, should this population be redirected to other less expensive social service resources available in the community? And, if so, how?

Our sample is drawn from two outpatient clinics which incorporate social services into their health care system. But, what about the mass of older persons who receive their medical care elsewhere, for example, from private physicians? It seems to me that service providers need to have a link with private practitioners and other health care settings so that appropriate referrals can be made to community services. Geriatric practitioners are well aware of the magnitude of social and environmental factors which impinge on their patients and they need the opporutnity to refer patients in need to appropriate community resources. We know that there is a vast array of services available in the community, but the people in need of those services must be reached in order to benefit from them.